MONROE COUNTY
FLEXIBLE SPENDING ACCOUNT
CLAIM FORM

Please read these instructions before completing the claim form:
1. Employee must complete Part I. (If applicable, complete Part II and/or Part III).
2. Instructions for Part II "Health Care Expenses":
   A. Expenses covered by your spouse's or your health care plan(s) must be submitted to that/those plan(s) prior to submission to your flex medical reimbursement account. Attach a copy of the explanation of benefits statement or itemized bill showing health care plan(s) payment(s) in order to claim your patient responsibility amounts.
   B. For all other eligible health care expenses, attach an itemized receipt that clearly states the name and address of the provider, date of service, service rendered, name of person receiving the service and the amount charged
3. Instructions for Part III "Dependent Care Expenses": Attach a copy of a receipt that includes the Federal ID# or SS# of the provider, name and address of the provider, name of dependent receiving the service, amount paid, and date (or date range) the service was provided. Federal form W-10 for each dependent care provider must be on file in our office.
4. Read the Employee Statement, sign and date the form.
5. Mail (or fax) the completed form to the address (or fax number) provided on this form.

Part I: Employee Information (Please Print)

Employee Name:	**Employee Social Security Number:**

Address:	**New Address?** YES NO

Daytime Phone	**Evening Phone**

Part II: Medical Expenses (Please Print)

Covered Person	Date of Service	Provider	Type of Service Please check the appropriate box for each expense(s) **MD**=medical **RX**=prescription **VS**=vision **DN**=dental **OT**=other	Amount Claimed	Admin. Use
			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
			MD ☐ RX ☐ VS ☐ DN ☐ OT ☐		
			Medical Expenses Subtotal	**$**	

Part III: Dependent Care Expenses (Please Print)

Dependent	Date of Birth	Provider	Date(s) of Service MM/DD/YYYY		Amount Claimed	Admin. Use
			From:	To:		
			From:	To:		
			From:	To:		
			Dependent Care Expenses Subtotal		**$**	

Total Amount Claimed	**$**

Employee Statement:

I request payment from my Cafeteria/Flexible Benefits Account(s) for the expenses itemized on this claim form. I certify that I have not received reimbursement under this Plan or from any other source for these expenses and that I will not seek additional reimbursement for the amount(s) paid by this Plan. I further certify that I have met all requirements for eligible expenses under this Plan. I understand that expenses for which I have been reimbursed cannot be claimed on my personal income tax return.

Employee Signature: _____ Date: _____

Send completed claim form to: Health Economics Group, Inc. (585) 241-9500, ext. 504
1050 University Avenue, Suite A (800) 666-6690, ext. 504
Rochester, NY 14607 FAX: (585) 241-9518